PREVENTING CHILDHOOD OBESITY – Introduction
An Overview of the Obesity Prevention Objective
and
Guidance for Counseling on the Growth Grid
Training Curriculum

OVERALL OBJECTIVE FOR THE ENTIRE SERIES

By the end of the 8-part training sessions, staff will be able to provide caregivers of children with a variety of health messages designed to decrease the incidence of childhood obesity and promote positive parenting skills in feeding young children.

OBJECTIVES (for the Introductory Section)

1. Staff will be able to verbalize the risk factors associated with childhood obesity.

2. Staff will be become familiar with the statewide Obesity Prevention Objective.

3. Staff will understand the procedures for providing Obesity Prevention contacts to participants and how to document in the chart.

4. Staff will be able to explain the results of the growth grid to parents of overweight children in a non-threatening manner.

MATERIALS

Staff Reference Sheet
Nutrition Education Plan Survey
Guidance for Implementing the Obesity Prevention Objective

BACKGROUND INFORMATION

A. Obesity Prevention: A statewide objective

The State Agency has developed a long-term objective on reducing the incidence of childhood obesity in the WIC Program.

What do you feel are some of the reasons that this particular objective was chosen?
Allow time for response and supplement with the following information as necessary, referring to the Staff Reference Sheet.

- NHANES data and usage of DH show increasing trends (Review and explain the statistics on the Reference Sheet).

- Healthy People 2010 has established an objective on obesity prevention.

- Surgeon General considers obesity to be an epidemic.

- Obesity increases risk of other health and psycho-social complications:
  Diabetes, hypertension, elevated cholesterol are now occurring even among children. Obese children experience discrimination and ostracism from other children, resulting in decreased self-esteem.

B. Obesity Prevention: A multi-faceted problem

Obesity prevention is a complex issue. Many different factors contribute to this trend.

Break down into small groups and distribute the Staff Reference Sheet. Ask each group to review the risk factors associated with obesity which are listed in bullet form on the Staff Reference Sheet. Ask them to identify which ones WIC can impact and which they cannot. Also have them discuss how they might intervene. Then discuss their conclusions as a large group.

(Depending on their conclusions, you may want to incorporate some of their ideas into the state objective. Each local agency may add additional methods to the statewide objective to fit their own needs.)

C. Obesity Prevention: A long-term objective

Preventing obesity involves education in a number of related areas:

- Physical activity promotion
- Promotion of parenting skills related to child feeding (Ellyn Satter Techniques)
- Education on choosing lower fat fast foods and convenience foods
- Parental role modeling
- Education on limiting sweetened beverages and snack food and increasing consumption of water, fruits and vegetables

In short, obesity prevention involves educating participants on 'the basics' of good nutrition and parenting skills in feeding young children. Because of the number of contacts which should be covered, the objective should be considered a long-term, on-going educational effort for parents and caregivers of children over the age of two. The objective should be aimed at increasing parental awareness of the above and motivating families to change behaviors.

REVIEW OF THE NUTRITION EDUCATION PLAN SURVEY AND THE STATEWIDE OBJECTIVE

A. Purpose of the 'Question Format' to the Nutrition Education Plan Survey

Distribute the Nutrition Education Plan Survey and provide the following explanation.

This nutrition education plan survey has been developed to assess the current attitudes among participants regarding various topics which relate to obesity prevention. The plan is designed as

a series of survey questions which ask participants how they think their child **should** eat or behave. The questions will serve as a springboard to discuss various tips to help parents get children to eat and behave as they **should** instead of as they do! Caregivers should **not** complete the survey questions all at once. Have the parent or caregiver complete *the appropriate section* of the survey which pertains to the particular topic that staff intend to discuss **at that visit.**

Nutrition education modules have been designed to provide guidance on how to review these questions with participants. There is a separate module for each question and each module will be reviewed at a training session so that everyone knows how to address these topics with participants.

B. Guidance for Implementing the Objective

Review with staff the information from "Guidance for Implementing the Obesity Prevention Objective". This guidance will need to be adapted to fit your own local agency plan.

C. Group Discussion of the Nutrition Education Plan Survey

Have staff review survey. After everyone is finished, discuss it as a group by asking the following question:

All surveys have limitations. What do you feel are the limitations with using the answers to this survey as a guide for developing nutrition education topics?

Allow time for responses. Supplement their answers with the following if not mentioned during the discussion:

- Some may not complete the survey accurately or honestly. They may answer it the way they think staff wants.

- Some may misread the questions.

In spite of these limitations, the surveys can still be used as a method to generate discussion with participants. However, it is best to **not** assume that their answers are accurate. Staff should take time to discuss individual questions regardless of the answer they provide.

COUNSELING CAREGIVERS OF OVERWEIGHT CHILDREN

The modules are designed to be used as a standard of care with *all* children to help prevent obesity. Four out of five children on WIC are *not* overweight. The parents of these children may be less likely to relate to the benefit of obesity prevention since they may feel that this would never happen to their child. Although the goal of this objective is obesity prevention, the method we will use with parents is to focus on the importance of exercise and nutrition for general health and development. The modules do not address obesity prevention directly. We will encourage parents to get their children moving and to employ good parenting techniques in feeding their children. It is hoped that obesity prevention will become a natural outcome of these educational efforts.

However, one out of five children on WIC are already obese and therefore need special consideration.

Allow time for staff to answer each question below and supplement their answer with the information in the bullets under each question.

Before going into the modules with caregivers, what actions should you take if the child is certified above the 85th and 95th percentile on the growth grid?

- First, visually assess the child. Does he appear overweight/obese or is he an unusually large-framed child. (There are always a few exceptions to the grids!) If visual assessment indicates that the child is an exception to the rule, review the module as you would for any other participant.

- If the child appears overweight/obese, assess the parent's perception of her child's weight and her readiness to change/take action.

How would you broach the subject of a child's weight status with the mother?
What kind of open-ended question could you ask that would not be overly upsetting to her?

- Your child is at the _____ percentile on the grid. The American Academy of Pediatrics calls this area of growth grid the 'at risk zone.' They say that children in this zone are more likely to become overweight teenagers.
  What are your thoughts on your child's growth grid?
  Has your doctor discussed your child's growth grid? What did he say?

OR

- Your child is above the 95th percentile on the growth grid. The American Academy of Pediatrics calls this area of the growth grid the 'overweight zone.' They say that children in this zone weigh more than they should for their height.
  What are your thoughts on your child's growth grid?
  Has your doctor ever discussed your child's growth gird? What did he say?

Note: Discussion of the growth grid may be upsetting to the mother. There may be no way to avoid it. Some may take it personally as an insinuation that she is a 'bad mother.' However, we are here to inform parents of areas of concern *and* to help them gain new skills as parents. Try to couch your statements as facts from AAP while affirming her feelings as a mother. Otherwise, you may come across as merely giving your own opinion!

Parents may respond to this question in several ways.

What if the parent becomes offended or even angry because she does not believe that her child is overweight or at risk?

- Apologize for upsetting her! Explain that you merely wanted to inform her of how AAP interprets the growth grids because you know that she is a concerned parent. Document in the chart that the child's weight status was discussed and that the parent was not receptive to discussion at that visit. Wait until the next visit to provide any other education. (She will need time to defuse and think about what you have said.) When she returns for the next visit, begin reviewing the information in the exercise promotion module as you would with any

other participant. Maybe as time goes on, the parent will express some interest in getting her child to slim down. If not, she will at least hear advice which she can apply to reverse the overweight trend in her child.

What if the parent is concerned about her child's weight and is interested in what she can do to get her child to slim down?

- Explain that you will adjust down the food package for her child.
- Encourage her to keep her WIC check pick up appointments because at each visit, you will discuss parenting tips to help her child slim down. She can even bring her child in for weight checks if she wants. At this point, proceed with the exercise module if time permits, or begin at the next visit. Adjust the information in the modules as needed to the individual's issues/needs.

Separate modules have **not** been developed for children who are already overweight. If parents incorporate the advice which staff will cover in the individual modules, overweight children will gradually slim down. The modules are designed to get the whole family involved rather than put an overweight child on a special program.

At this point, proceed to provide training on the individual modules.

PREVENTING CHILDHOOD OBESITY
Overall Objective
WIC Staff Reference Sheet

Over the past two decades, the percentage of obese children in America **doubled.** During the NHANES I survey (1971-1974), the incidence of childhood obesity among 4-5 year olds was 5.8%. In the most recent NHANES III survey (1988-1994), the incidence of obesity among 4-5 year olds increased to more than 10%.

Currently, obesity is defined as a BMI of 30 or greater and overweight is defined as a BMI of 25. A BMI of 30 corresponds to the 95th percentile on the WIC growth grids and a BMI of 25 corresponds to the 85th percentile. Prior to April 1999, the cut off risk code DH was the 95th percentile. Past usage of risk code DH among PA WIC children has been significantly higher than the national NHANES III data:

1994	14.1%
1996	14.8%
1997	14.8%

After April 1999, USDA lowered the cut off for DH to the 90th percentile which would include overweight children at risk for developing obesity. As a result of the revised criteria, June 2000 Nutrition Risk Usage data indicate that DH has risen to 21.1%. This coincides with current statistics which place **1 out of every 5** children in America as overweight.

The Surgeon General considers the incidence of overweight/obesity in this country to be an epidemic and Healthy People 2010 includes the following objective:

> Reduce to 5% or less the prevalence of overweight and obesity (at or above the sex- and age-specific 95th percentile of BMI) from the revised NCHS/CDC growth charts in children (aged 6-11) and adolescents (aged 12-19).

There are compelling reasons for making obesity prevention a national health initiative. Concomitant with the increase in obesity, the incidence of hypertension, diabetes and elevated cholesterol among children is also rising. Also, obese children face self-esteem and developmental issues since they are less likely to be accepted by other children.

The problem of obesity in America is multifaceted and defies a simple solution. The following factors all contribute to the growing trend:

- Lack of physical activity
  67% of children watch more than 2 hours of TV per day.
  Only 20% get more than 2 hours of activity per week.

- Safety concerns
  Some parents feel that their neighborhood is unsafe for outside play. They keep their children inside instead.

- Food availability
  America is the land of Big Gulps and Big Macs.

- Juice and beverage consumption
  Intake of sweetened beverages in this country has increased dramatically while intake of fruits and vegetables remains marginal.

- Flavor competition
  Nutritious foods must compete with the tempting tastes of sweet and salt.
  Kids inherently prefer these tastes. Children eat what they like!

- Food marketing geared to children
  Saturday morning commercials pique children's interest in salty and sweet treats.

- School policies
  Schools have decreased their Physical Education programs and added vending machines instead. Some schools even receive company rebates and incentives for the amount of soda sold on campus!

- Poor parental role models
  Parents complain of lack of time. They buy convenience and fast foods instead. Parents also prefer sweet and salty treats!

- Fewer family meals
  Children are eating many meals, often fast foods, away from home. Family meals are becoming less frequent. By the time children are in school, parents have little control over the kinds of foods their children choose.

- Obese parents
  There is much greater risk if parents are obese.

Considering the complicated interplay of factors, preventing childhood obesity must be a long-term objective aimed at increasing parental awareness of the above and motivating *families* to change behaviors. The WIC Program provides an ideal place and time to intervene. Therefore, a statewide objective for obesity prevention has been established which involves an on-going educational effort to increase physical activity, provide parenting information on child feeding, make healthier fast food choices, limit consumption of sweetened beverages, reduce fat intake and increase fruits and vegetables.

GUIDANCE FOR IMPLEMENTING THE OBESITY PREVENTION OBJECTIVE

Target Audience

Parents/Caregivers of children over the age of two.
The Obesity Prevention (OP) series is a nutrition education plan for children participating in the WIC Program. The series focuses on healthy eating habits and exercise, which apply to almost all children, regardless of where they appear on the growth grid. Exceptions to the above *may* include extremely underweight, high risk children or children with developmental problems. Extremely overweight children should be referred to appropriate services in your area. However, the information in the series can supplement the services in your area.

High risk children are exempted from the objective. However, if staff feel the material covered in this series is applicable to a particular high risk child, the Obesity Prevention series may be included as a part of a high risk nutrition education plan.

Documenting Contacts

The Introduction to the Obesity Prevention series provides staff with an overview of the statewide objective as well as guidance on how to discuss the growth grid with parents of *overweight* children. Discussion of growth grids is *not* an Obesity Prevention nutrition education contact. However, staff have requested guidance on how to explain the growth grids to parents of overweight children in a tactful, non-threatening manner. When staff use the guidance provided to review growth grids with parents or caregivers, they should continue to document #54 on the NER. This contact is routinely provided when children are certified for DH.

Staff have two options for documenting Obesity Prevention topics which are covered in Parts 1-7 of the series: the NER Form or the Nutrition Education Plan Survey (See Introduction).

To document on the NER

Use the following 'special' codes instead of the number codes listed in Policy 5.08.

- OP1: Increasing Physical Activity/Reducing TV Viewing (Part 1)
- OP2: Teaching Children Positive Attitudes Toward Food (Part 2)
- OP3: Choosing Healthy Snacks (Part 3)
- OP4: Limiting Juice Intake (Part 4)
- OP5: Choosing Fast Foods Wisely (Part 5)
- OP6: Increasing Fruits and Vegetables (Part 6)
- OP7: Reducing Fat Intake (Part 7)

Staff only need to document the *code*, not the complete name. By documenting this code, staff are verifying that they have followed the nutrition education module for that contact, discussed the topic with the participant and provided the recommended flyers. Therefore they do *not* need to document what they said to the participant in the Comments Section nor do they need to document the materials given, unless they also provided pamphlets other than those included with the module.

Each nutrition education module ends with an open ended question which asks the participant which ideas she will try. In the Comments Section, staff are to summarize what the participant says. This way, staff can evaluate the effectiveness of the contact given and they can follow up at the next visit. Staff should also document any other comments or concerns that require follow-up at a future contact. Documentation of the participant's response verifies that the contact was interactive rather than didactic.

To Document on the Nutrition Education Plan Survey

Rather than use the NER, staff may record their comments directly on the survey which the participant completes. In the white space below each question, staff can date the contact, record the participant's response and sign their name. They do not need to document the number code, because the question already indicates which portion of the Obesity Prevention series was discussed at that visit.

The disadvantage of using the survey form for documentation purposes is that staff will still have to document other contacts on the regular NER. This may become confusing.

Implementing the Series

Children should receive a minimum of one Obesity Prevention contact per certification period. This will ensure that by the time the child is five, he will have received most of the contacts. Limiting the goal to one contact per certification gives staff the flexibility to discuss other nutrition topics which are pertinent to the family. Local Agencies may opt to complete two Obesity Prevention contacts per certification, if preferred, or provide two Obesity Prevention contacts at one visit while using the other visit to discuss other issues. Each Agency has the flexibility to determine the number of contacts they will provide within a given time frame provided they meet the minimum of one OP contact per certification.

Staff should be trained and ready to begin implementing the series with participants by January 2001. Training staff on all sections of the series at one time may be administratively unfeasible. It may be more effective to train staff on one or two sections at a time.

The series need not be completed in any specific order. Each topic/question on the Nutrition Education Survey can stand alone. Local Agencies may decide which topic they want to focus on and for what period of time. Participants should only complete the Nutrition Education Survey questions(s) that pertains to the particular topic(s) the agency plans to address at that visit. The other questions on the survey should be left blank for discussion at future contacts.

Training Staff
It is preferable to train staff on an OP topic shortly before they are ready to implement it. This will help staff become proficient with the recommended counseling techniques.

Ensure that staff understand and are comfortable using the counseling techniques recommended in the curriculums and the modules. This is a vital part of this objective. Since the modules are interactive, participants may ask staff difficult questions. It is also crucial that staff have enough background information and knowledge of parenting tips to help field the variety of questions which participants may raise.

Monitoring Staff
When conducting Program Reviews, the State Agency will monitor staff who provide Obesity Prevention contacts. The State Agency nutritionist will be looking for interactive contacts rather than a didactic presentation. They will also be checking the comments section on the NER or the Nutrition Education Survey Plan to evaluate the effectiveness of the contact provided.

Name _____ ID # _____

Nutrition Education Plan Survey

1a. How would you rate your child's activity level (running, jumping, crawling, Big Wheels, tricycles, etc.)?
a. Over active. I wish my child would slow down! b. Active. I think my child gets enough exercise.
b. Somewhat active. I think that my child should get more exercise!

1b. How many hours of TV/video/computer *should* children watch or play *each day?*
a. Children should watch very little. b. Less than ½ hour daily. c. Between ½ to 1 hour daily.
d. Between 1 ½ to 2 hours. e. About 2 hours or more. f. It really doesn't matter.

2. How often do you sit down to eat with you child?
a. About once a week. b. A few times a week. c. Once a day. d. More than once a day.
e. I usually don't sit down with my child because _____

3. How often do you think children should be allowed to eat candy, cookies, corn curls, chips, cake, etc.?
a. Occasionally. b. About once a week. c. A few times a week. d. Once a day.
e. There is no need to limit how often.

4. How often should children be allowed to drink soda, Kool-Aid, Gatorade, iced tea or juice etc.?
a. Occasionally. b. About once a week. c. A few times a week. d. Once a day.
e. There is no need to limit how often.

5. How often should children be allowed to eat at fast food restaurants, mini-marts, etc.?
a. Occasionally. b. About once a week. c. A few times a week. d. Once a day.
e. There is no need to limit how often.

6. How often should children eat vegetables?
a. Occasionally. b. About once a week. c. A few times a week. d. Once a day.
e. Twice or more a day.

7 What kind of milk should children over the age of two drink?
a. Whole b. 2% c. 1% d. Skim milk e. It doesn't matter, whatever kind they like.